STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		01	COMPLETED	
155478		B. WIN			04/11/	2012	
			Б. WH		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			OWARD DR		
TIMBERS OF JASPER THE			JASPER, IN 47546				
(X4) ID	SUMMARY S	MMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG			DATE
K0000							
Roooo	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).  Survey Date: 04/11/12  Facility Number: 000314 Provider Number: 155478 AIM Number: 100274210  Surveyor: Lex Brashear, Life Safety Code Specialist  At this Life Safety Code survey, The Timbers of Jasper was found not in compliance with Requirements for Participation in		K00	000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.  This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or after		
	Medicare/Med	•					
	•	the 2000 edition of					
	the National Fi	re Protection					
	Association (N	FPA) 101, Life Safety					
	Code (LSC), Ch	napter 19, Existing					
		ccupancies and 410					
	IAC 16.2.						
	1/30 10.2.						
	This one story determined to construction a	be of Type V (000)					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000314

	OF CORRECTION  OF CORRECTION  155478	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	(X3) DATE SURVEY COMPLETED 04/11/2012			
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE COMPLETION			
	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 76 and had a census of 72 at the time of this survey.  Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/12/12.  The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:						

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 01		01	COMPLETED		
	155478		B. WING			04/11/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OWARD DR		
TIMBERS OF JASPER THE			JASPER, IN 47546				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0038 SS=E		ODE STANDARD ranged so that exits are					
		e at all times in accordance					
	Based on obser	vation and	K00	38	The facility's intent is to ensur		04/12/2012
	interview, the facility failed to				exit access is arranged so that exits are readily accessible at		
	ensure 1 of 8 e	mergency exit			times. What corrective	ווג	
	doors which wa	as provided with a			action(s) will be accomplished for		
	delayed egress	•			those residents found to have		
	connected to the				been affected by the deficient practice 1. The Maintenance Director contacted the licensed contractor		
		equate provisions					
		immediately following survey. C cupants by means such as a eypad unlocking device, a remote nlocking device, or keying of the immediately following survey. C 4/12/12, the vendor completed the repair and tested. The door released properly when fire alarm		On			
					•		
	_				1	31111	
	locked doors with keys carried by all staff at all times. LSC Section 19.2.1 refers to LSC Chapter 7. LSC 7.2.1.6.1 requires buildings				How will you identify other		
					residents having the potential		
				be affected by the same deficient			
					practice and what corrective action will be taken		
	-	cted throughout by an			1. No other doors were		
	approved supervised automatic fire alarm system may have doors				identified.		
					What measures will be put		
		approved, listed,			place or what systemic change		
		locks which shall			you will make to ensure that the deficient practice does not reci		
	automatically u	·			1.The Maintenance Director		
	actuation of an	approved			check the door release during		
	supervised auto	omatic fire alarm			monthly fire drills to ensure		
	system installe	d in accordance			proper working order. The Maintenance Director will		
	with Section 9.0	6. This deficient			document findings on fire drill		
	practice could a	affect 27 residents,			report. Any findings needing		
	l ·	and visitors in 400			repair, the Maintenance		
	hall.	-			Director/Designee will		
					immediately contact to have the		
					contracted vendor complete		

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Event ID: FCBV21

Facility ID: 000314

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	(X2) MULTIPLE CO	ONSTRUCTION  01	COM	E SURVEY PLETED 1/2012		
		155478	B. WING STREET A	ADDRESS, CITY, STATE, ZIP		1/2012		
NAME OF PROVIDER OR SUPPLIER  TIMBERS OF JASPER THE			2909 HOWARD DR JASPER, IN 47546					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	testing the fire during a tour of the Maintenand hall exit door we gress and equidelayed egress (magnetic lock) exit this door wo door for 15 seefire alarm systedigit code on the fire alarm sactuated, this erelease from the automatically.	rvation on 1:35 a.m. while alarm system of the facility with the Director, the 400 was locked against slipped with a locking device ). The only way to was to push on the the conds, actuate the tem or press a five the keypad. When the system was exit door did not the magnetic lock This was by the Maintenance		repair. How the corrective as be monitored to ensu deficient practice will i.e., what quality assu program will be put in 1. The Executive Director/Designee will monthly fire drill report documentation of reled doors operation durin 2. To ensure complist Maintenance Director responsible for the country these reviews will be the CQI committee on the ED. If threshold on the achieved an action be developed to ensure compliance.	re the not recur, urance ato place  Il review rts for ease of ag test. ance, the r/Designee is completion of d results of reviewed by verseen by of 100% is on plan will			